| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 005070 | A. BUILDING: _____ B. WING _____ | 02/21/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAINT JOSEPH REGIONAL MEDICAL CENTER - PLYM | 1915 LAKE AVE PLYMOUTH, IN 46563 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S 000 | INITIAL COMMENTS<br><br>Surveyor: 33212<br>Facility Number: 005070<br><br>Type of Survey: State Licensure Off Site JCAHO Accreditation Survey<br><br>Date of JCAHO On Site Survey - Hospital full survey 2/20-21/2014<br><br>Date of ISDH off site review - 09/18/2014<br><br>Reviewer/Surveyor -Nancy Otten, RN, PHNS<br><br>Based on review of the 2/21/2014 JCAHO Accreditation Survey Report, it has been determined that St. Joseph Regional Medical Center meets the requirements for Hospital Licensure in Indiana for 2014. | S 000 | | |